NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Technology Appraisals and Guidance Information Services

Static List Review (SLR) report

Title and TA publication number of static topic:	**TA59; The clinical effectiveness and cost effectiveness of electroconvulsive therapy (ECT) for depressive illness, schizophrenia, catatonia and mania**
Final decision:	The guidance will remain on the 'static guidance list'.

1. Publication date:	April 2003.
2. Date added to static list:	January 2008 (catatonia, prolonged or severe manic episode and schizophrenia indications). Note that the indication for depression has been updated in Clinical Guideline CG90: depression in adults.
3. Current guidance:	1.1 It is recommended that electroconvulsive therapy (ECT) is used only to achieve rapid and short-term improvement of severe symptoms after an adequate trial of other treatment options has proven ineffective and/or when the condition is considered to be potentially life-threatening, in individuals with: • catatonia • a prolonged or severe manic episode. 1.2 The decision as to whether ECT is clinically indicated should be based on a

	documented assessment of the risks and potential benefits to the individual, including: the risks associated with the anaesthetic; current co-morbidities; anticipated adverse events, particularly cognitive impairment; and the risks of not having treatment. 1.3 The risks associated with ECT may be enhanced during pregnancy, in older people, and in children and young people, and therefore clinicians should exercise particular caution when considering ECT treatment in these groups. 1.4 Valid consent should be obtained in all cases where the individual has the ability to grant or refuse consent. The decision to use ECT should be made jointly by the individual and the clinician(s) responsible for treatment, on the basis of an informed discussion. This discussion should be enabled by the provision of full and appropriate information about the general risks associated with ECT (see Section 1.9) and about the risks and potential benefits specific to that individual. Consent should be obtained without pressure or coercion, which may occur as a result of the circumstances and clinical setting, and the individual should be reminded of their right to withdraw consent at any point. There should be strict adherence to recognised guidelines about consent and the involvement of patient advocates and/or carers to facilitate informed discussion is strongly encouraged. 1.5 In all situations where informed discussion and consent is not possible advance directives should be taken fully into account and the individual's advocate and/or carer should be consulted. 1.6 Clinical status should be assessed following each ECT session and treatment should be stopped when a response has been achieved, or sooner if there is evidence of adverse effects. Cognitive function should be monitored on an ongoing basis, and at a minimum at the end of each course of treatment. 1.7 It is recommended that a repeat course of ECT should be considered under the circumstances indicated in 1.1 only for individuals who have catatonia or mania

	and who have previously responded well to ECT. In patients who are experiencing an acute episode but have not previously responded, a repeat trial of ECT should be undertaken only after all other options have been considered and following discussion of the risks and benefits with the individual and/or where appropriate their carer/advocate. 1.8 This recommendation has been updated and replaced by NICE clinical guideline 90. 1.9 The current state of the evidence does not allow the general use of ECT in the management of schizophrenia to be recommended. 1.10 National information leaflets should be developed through consultation with appropriate professional and user organisations to enable individuals and their carers/advocates to make an informed decision regarding the appropriateness of ECT for their circumstances. The leaflets should be evidence based, include information about the risks of ECT and availability of alternative treatments, and be produced in formats and languages that make them accessible to a wide range of service users.
4. Research recommendations from original guidance:	5.1 There are a number of ongoing research projects that include studies of clinical and cost effectiveness in specific groups and an examination of the effects of seizure parameters. 5.2 Further research is urgently required to examine the long-term efficacy and safety of ECT, including its use as a maintenance therapy and its use in particular subgroups who may be at increased risk, for example older people, children and young people, and during pregnancy. This research should reflect modern techniques and the use of ECT in comparison with and in conjunction with the antipsychotic and antidepressant drugs used in current practice. In addition to the use of appropriately validated psychometric scales, outcome measures should include user perspectives on the impact of ECT, the incidence and impact of important side effects such as

	cognitive functioning, and mortality. 5.3 Further research into the mechanism of action of ECT is encouraged, because it may provide important information on aetiology and future treatment strategies. 5.4 It is clear that the stimulus parameters impact on the safety and efficacy of the technique and recent research needs to be augmented. Further evaluation is needed of whether it is necessary to induce a full seizure for therapeutic effect, and how the efficacy and cognitive effects are influenced by the amount by which the applied electrical dose exceeds the seizure threshold. 5.5 More research is also needed to determine the cost effectiveness of ECT. In particular, better quality-of-life information is needed for people considered for, or who have received, ECT.
5. Current cost of technology/ technologies:	There are no more recent data available beyond what is included in guidance.
6. Cost information from the TA (if available):	*"Six treatment sessions of ECT have been estimated to cost £2475. This does not include inpatient costs, estimated as £171 per day".* *"The number of sessions undertaken during a course of ECT usually ranges from 6 to 12, although a substantial minority of patients respond to fewer than 6 sessions. ECT is usually given twice a week; less commonly it is given once a fortnight or once a month as continuation or maintenance therapy to prevent the relapse of symptoms. It can be given on either an inpatient or day patient basis".*
7. Alternative manufacturers:	Not applicable.
8. Changes to the original indication:	None.
9. New relevant trials:	There are no trials that are relevant to indications other than depression.

10. Relevant NICE guidance (published or in progress):	Depression in adults: The treatment and management of depression in adults. Clinical Guideline CG90. Issued: October 2009. The review proposal process is ongoing for this guidance. Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care. Clinical Guideline CG82. Issued: March 2009. An update of this guideline is currently in progress. Psychosis with coexisting substance misuse: Assessment and management in adults and young people. Clinical Guideline CG120. Issued: March 2011. Review date: March 2014. Antenatal and postnatal mental health: Clinical management and service guidance. Clinical Guideline CG45. Issued: February 2007. A review of this guidance is being scheduled into the NICE work programme. The management of bipolar disorder in adults, children and adolescents, in primary and secondary care. Clinical Guideline CG38. Issued July 2006. A review of this guidance is being scheduled into the NICE work programme.
11. Relevant safety issues:	No new safety issues were identified.
12. Any other additional relevant information or comments:	None.

13. Technical Lead comments and recommendation:	No new evidence that post-dates the decision to place TA 59 on the static list has been found for the use of ECT for catatonia, prolonged or severe manic episode and schizophrenia. The only research that post-dates the decision to place TA 59 on the static list is on depression, which has been subsumed into Clinical Guideline 90. A review would be unlikely to be considered good use of NHS resources because the recommendations would be unlikely to change.

Appendix 1 – explanation of options

Options	Consequence	Selected – 'Yes/No'
The guidance will remain on the 'static guidance list'	The guidance will remain in place, in its current form, unless NICE becomes aware of substantive information which would make it reconsider. Literature searches are carried out every 5 years to check whether any of the Appraisals on the static list should be flagged for review.	Yes
The decision to review the guidance will be deferred to specify date or trial	NICE will consider whether a review is necessary at the specified date. NICE will actively monitor the evidence available to ascertain when a consideration of a review is more suitable.	No
A full consideration of a review will be carried out through the Review Proposal Process	There is evidence that could warrant a review of the guidance. NICE will schedule a consideration of a review, including a consultation with relevant consultees and commentators.	No
The guidance will be withdrawn	The guidance is no longer relevant and an update of the existing recommendations would not add value to the NHS. NICE will schedule a consideration of a review, including a consultation with relevant consultees and commentators.	No

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